ence of an abnormal constituent during the latter half of the first week, during the second week (ninth to the twelfth days), and on the thirty-first day than at any other period of the illness. The cases seemed to divide themselves into two groups: (1) Cases of "early" albuminuria, and (2) cases of "late" albuminuria. Twelve of the cases came under the heading of "early" albuminuria. In nine of these twelve cases the albumin disappeared only to reappear again later in the disease, the interval during which the urine was free from albumin varying in these cases from three to forty-eight days.

Mahomed claims that in some cases of nephritis, notably in scarlet fever, one sometimes observes a stage in which only blood-coloring matter can be detected in the urine. This stage he terms the "pre-albuminuric stage." The explanation advanced was that early in the disease there is observed a condition of high tension in the arterial system, which, if sufficiently severe, leads to transudation of hæmoglobin before the appearance of albumin in the urine. A similar but converse phenomenon is sometimes observed during the decline of a nephritis, the albumin disappearing first, the hæmoglobin later. Dr. Thomson has suggested the term "post-albuminuric" stage for this period. Dittmar was not able to confirm these observations in the study of his cases.

The conclusions that Dittmar arrives at are as follows:

1. That albuminuria or hæmaturia, or both, occurred in 52.7 per cent. of the cases observed.

2. That the cases seemed to divide themselves naturally into three classes: (*a*) Those of pure albuminuria in which albumin only was detected; (*b*) those of hæmaturia, in which "blood" seemed to be present; (*c*) those of albuminuria and hæmaturia, the albumin being greatly in excess of the hæmoglobin as found in the blood.

3. That dropsy or œdema of the superficial parts was observed unmistakably in only three of the cases.

4. That a "pre-albuminuric" and a "post-albuminuric" stage (if the word be allowed) do not exist in the proper sense of the terms.

5. That a pulse of "high" tension was not an invariable accompaniment even of undoubted nephritis.

The Smegma Bacillus.—Important additions to our knowledge of the smegma bacillus have been made by CZAPLEWSKI and LASER (*Münch. med. Woch.*, 1897, No. 43). These observers have been able to cultivate the organisms. Czaplewski used nutrose-serum-agar; Laser used agar smeared with human blood. The colonies grow rapidly, resembling those of streptococci or diphtheria bacilli. The tenacity with which the bacilli resist acids in decolorizing was preserved in the cultures, proving that the resistance is not due to fat from the medium, but to some other cause. Laser was unable to discover any pathogenic action in white mice and guinea-pigs. The practical importance of these investigations, if confirmed, is very great. Within twenty-four hours a culture can be obtained. The appearance of the colonies and the peculiar staining reactions, combined with the rapid growth, make it easy to distinguish the organisms from others, so that inoculations, requiring as they do so much more time, will no longer be necessary.

The Sputum in Cancer of the Lung.—HAMPELN (*Zeitschrift für klin. Med.*, Bd. xxxii., p. 247) gives the results of a rather rich experience. He agrees with former writers that the hemorrhagic character of the sputum is important, though he claims there is no characteristic tint. Moderate and temporary hemorrhages are more likely to be encountered, though in rare cases the bleeding is prolonged—to two months in one case—and copious. As to the microscopic characteristics of the sputum, it has heretofore been held that only the finding of actual bits of broken-down new-growths is of diagnostic value, yet such bits have been rarely found, only once among the authors cited. Hampeln has made careful comparative examinations of the cells found in the sputum in various diseases. He holds that the normal, non-pigmented polygonal cells of the alveoli occur so rarely, if at all, in sputum, that they do not play a great part in differential diagnosis. When in disease cells are found which plainly differ from the ordinary pavement and cylinder cells of the mouth or air-passages—cells which are non-pigmented, polymorphous, polygonal, of various sizes, sometimes gigantic, with plain nucleus and nucleolus, single or in masses—the diagnosis of new-growth is permissible. The seat or origin of the growth cannot be determined from the character of the cells, so that a distinction between bronchial and pulmonary cancer is not possible. A number of illustrations of cells of various kinds, including some from cases of cancer, add to the value of the article. It is interesting because it shows the reaction against the idea long prevailing, that there is nothing diagnostic about the cells of new-growths. That these are not specific in shape, as was once thought, is, of course, admitted by the author; yet there are many details of size, shape, character of nucleus, and staining properties that, when considered in relation to their source, may enable an experienced observer to draw conclusions of value.

Mucus in Stools.—ADOLF SCHMIDT, who has done such useful work in the application of staining-methods to mucus in sputum, has made a valuable contribution to the present subject, one that is all the more important because the examination of feces is strangely neglected by many. Although the result of the present work may seem trifling, yet it includes a revision of many points that were long thought to be settled, but in fact were not. The details are indispensable to clinical investigators, but it will suffice here to give some of the author's conclusions. The conception of a special disease, enteritis membranacea, cannot be based on the quantity and shape of mucus in the stools. The clinical picture described by Nothnagel under the name of colica mucosa may, however, be separated from other forms of enteritis.

The basis of most membranous bodies in feces is mucin. The refractoriness of these masses is due to the constant presence of fats and soaps in considerable quantity. Fibrin has never been positively demonstrated in the mucous discharges. The number of round cells in intestinal mucous is not always so small as might be supposed from the examinations of fresh preparations. For the diagnosis of ulcerative processes, the absence of mucus among the cells is more important than the appearance of large numbers of round cells. We have at present no certain guides to the sources of mucus or the cells in the mucus. The strongest evidence of a source in the small intestine is the digestion of the cell bodies, leaving the nuclei free. Except in case of very rapid transit through the intestine, mucus never passes undissolved from the small intestine to the anus.—*Zeitschrift für klin. Med.*, Bd. xxxii., p. 260.

Bacteriuria.—R. BARLOW (*Deutsches Archiv für klin. Med.*, Bd. lix., p. 347) has gathered together from the literature and his own experience notes on sixty-five cases of bacteriuria. In these sarcinæ were present in twenty-two cases; colon bacilli nineteen times—seventeen in pure culture, twice with staphylococci; the latter alone in three cases; in one each an H_2S-forming bacillus and an undetermined bacillus. With regard to the source of the bacteria, it is interesting to note that, although albumin has been noted in some cases, there is an important error in such determinations, since the heat and nitric-acid test gives an opacity in bacteriuria sometimes when other albumin tests fail. In no cases have casts been found, unless there was a complicating nephritis or heart disease. The renal origin is, therefore, not yet demonstrated. The theory of Posner, that the bacteria come from the intestines, is not looked on favorably by the author. His objection is based on the negative results of the bacteriological examination of the blood, the sterility of the pelvis of the kidney in a case of Krogius, the absence of turbidity in the urine as it comes from the ureters, and the absence of signs of intestinal putrefaction in the urine. That the bacteria come from the urethra is negatived by the large number of coli infections and the relative scarcity of staphylococci, in marked contrast to the relative frequency of these forms in the urethra. Barlow inclines to the belief that the infection often takes place by means of lesions of the intestine, citing such lesions as fissures or lacerations of the anus, fistula *in ano*, and even severe massage of the prostate and seminal vesicles through the rectum.

Even more difficult to explain than the source of the urinary infection is its seat. In a case of Goldenberg's the bacteria seemed to come from the seminal vesicles, but in general we are completely ignorant of the seat of reproduction of the bacteria. They certainly do not live only in the bladder, or the difficulty of removing the condition would be much less than it is. As to the symptoms, the urine is always turbid, opalescent, and looks, especially when shaken, as if fine powder were suspended in it. Colon bacilli usually cause a fetid odor. The reaction is acid, alkaline, or neutral. In rare cases the urine is ammoniacal. On standing, a sediment usually forms, consisting exclusively of bacteria and mucus. The supernatant fluid, however, does not clear, but may become more turbid. Albumin, and at times sugar, may be present. Subjective symptoms may be absent, or there may be local symptoms of variable severity, from tickling in the urethra to severe irritation and shooting pains, and even malaise, fever, enlarged spleen, and chills.

The diagnosis is easy, if the urine is passed in several portions and the examinations made at once. Prognosis is not altogether favorable. Remissions are frequent, and the disease may last for years (fifteen in a case of Finlayson).

The treatment should be antiseptic, salol internally, and silver nitrate or argonin locally, being very useful. Disease of urethra, prostate, and seminal vesicles must be considered.

SURGERY.

UNDER THE CHARGE OF

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A Case of Wandering Œdema.—MASTERMAN (*British Medical Journal*, April 3, 1897) reports an interesting case of œdema which he considers to have been probably due to septic infection. The patient was a boy, aged eight years; the œdema first made its appearance after a period of pain in the left leg, which became very much swollen and tense, with purpuric patches, irregular and raised. The left arm was next involved, and then the head; both upper eyelids were intensely œdematous; also the area between the eyes and over the temples. The pulse was slightly quickened and the temperature was a little over 100° F.; its highest point was 101.2° F. The lower eyelids, ears, and occipital regions were next involved. Then followed an œdema of the right arm, then of the back, the œdemas disappearing in the same order in which they made their appearance, the vesicles becoming purulent and then drying up.

The attack was closed by a severe acute dysentery. Blood and matter were very copious and tenesmus severe.

The treatment employed was quinine internally, extract of belladonna with glycerin externally and later lotio plumbi cum opio.

External Pharyngotomy for Epithelioma.—MORTON (*British Medical Journal*, March 27, 1897) reports a case of epithelioma of the tongue which involved the right tonsil and floor of the mouth and in which he removed, by an operation similar to Kocher's method for excision of the tongue, the tonsil, floor of the mouth, and half of the tongue. The patient made a complete recovery, and there was no sign of return six months after the operation.

The author did not ligate the external carotid artery; he divided and turned apart the divided portions of the lower jaw, so as to give free access to the tonsillar region for the purpose of dealing readily with all bleeding vessels.

The patient was fed by a tube passed into the stomach, which was left in position; attempts at swallowing were thus avoided, and no food got into the mouth; moreover, the patient began at once to take large quantities of nourishment.

The patient was tracheotomized prior to the operation and the pharynx packed with sponges. The tracheotomy tube was retained for ten days and